

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-001339

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 139

Primary Registration District No.

Registrar's No. 9

FILED FEB 4 1963

VS 300
Rev. 4/59

1 0440

2 0440

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4 0

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9 4500

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12 86-2

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY HOLT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN OREGON		Length of stay in 1b. 3 yrs	c. CITY OR TOWN MOUND CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BROWNE NUR. HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DAVID NEWTON SLONIKER		4. DATE OF DEATH Month Day Year JAN. 29, 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS	11. BIRTHPLACE (City and state or country) MARYVILLE, Mo.
13a. FATHER'S NAME JONAS SLONIKER		13b. MOTHER'S MAIDEN NAME MELISSA J. THORNTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way of dates) yes SPANISH-		16. SOCIAL SECURITY NO.	
17. INFORMANT CHARLES SLONIKER - Maitland Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial PNEUMONIA.		INTERVAL BETWEEN ONSET AND DEATH 30 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) MARKED ARTERIOSCLEROTIC & SENILE CHANGES 2 years.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11-28-60 to Jan 29, 63 and last saw her/him alive on Jan 29, 63 Death occurred at 5:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Howard E. Colkin D.O.		22b. ADDRESS Oregon Mo.	
22c. DATE SIGNED 2-1-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-31-1963	23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE	23d. LOCATION (City, town, or county) (State) MOUND CITY, Mo.
24. FUNERAL DIRECTOR JAMES H. CRAWFORD, MOUND CITY, Mo.		25. DATE RECD. BY LOCAL REG. 2-1-1963	
26. REGISTRAR'S SIGNATURE James H. Crawford			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

MAR 15 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James H. Crawford

Licensed Embalmer No. 4796

P. O. Address

Thousand City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.